Primary Stroke Service

Stroke Patient Management Tool(TM) Coding Instructions

Legend

Stroke PMT fields
S Suggested Sources for Abstraction

Entry Criteria

Patients with a primary diagnosis of the following can be included:

- Ischemic Stroke
- Transient Ischemic Attack (TIA)
- Subarachnoid Hemorrhage
- Intracerebral Hemorrhage
- Stroke not otherwise specified

For a full description of the stroke diagnoses refer to the definition for Clinical hospital diagnosis related to stroke.

Include:

- Patients initially admitted to the hospital for one of the diagnoses even if they later transfer or expire.
- Patients directly admitted to nursing units within the hospital without first being seen in the Emergency Department (ED). This includes patients with acute ischemic stroke who receive treatment at another hospital and are transferred to your hospital.
- Patients who refuse treatment or who have Do Not Resuscitate orders.
- You may include or exclude in-hospital stroke. Please note in-hospital strokes are excluded from all Performance Measures.

Exclude:

- Patients who die in the emergency room.

Additional Entry Criteria and case assertainment information is available under the following links:
Massachusetts Primary Stroke Service Licensure Registry (PSS)

General notation:

- ND or No/ND = Not Documented. Select ND when there is no documentation in the medical record to explain why a treatement or intervention is not performed or evidence of a condition.
- NC = A reason for non-treatment was documented in the medical record (e.g. not indicated, contraindicated, patient/family refused).

- UTD = Unable to determine.

Abstraction Guidelines:

- Make use of the $ Suggested Sources for Abstraction as a guide to help find medical documentation for each data element. **Only** abstract data which is clearly documented in the medical records. When in doubt, consult with your local Stroke champion or Stroke team leader for clarification.
- **Date Precisions**: Date and Time fields have an additional "Precision" drop-down right above the MM/DD/YYYY HH:MI blanks. The Precision is used to indicate how much of the Date and Time data is known and can be abstracted. For most of the Stroke Date and Time fields, there are three Precision levels.
    - The default level is "MM/DD/YYYY HH:MI". This is used if the entire Date and Time information is available. Time should be entered in 24hr/Military format.

    - If the Time is ND, select a Precision of "MM/DD/YYYY". The "HH:MI" blanks will become grayed-out.

    - If the Date is ND, select a Precision of "Unknown". The whole "MM/DD/YYYY HH:MI" field will become grayed-out.

Suggested Sources:

Pre-hospital Data may include EMS Patient Care records (also known as transport sheets, trip sheets, or trip records).

Admission Data may include:

- Admission sheet
- Physician documentation (including Admitting physician notes, consultation notes, ED physician notes, Physician's hospital admission, transfer, or ED discharge notes, progress notes)
- ED documentation (including ED nurse notes, ED order sets or pathway documentation, ED physician notes, ED record, ED triage sheet, Registration form, ED vital signs graphical record)
- Inpatient documentation (including physician notes, history and physical, mediction documentation, nurse progress notes, nursing admission assessment note, physical or occupational therapy consultation or progress notes, speech pathology consultation or progress notes, diet or nutrition services consultation or progress notes)

Hospitalization Data may include:

- Physician documentation (including Acute physician or nursing notes, Acute Stroke Pathway documentation, Consulation progress notes, Diagnostic report, Physician progress notes, Progress notes)
- Inpatient documentation (including physician notes, history and physical, mediction documentation, nurse progress notes, nursing admission assessment note, physical or occupational therapy consultation or progress notes, speech pathology consultation or progress notes, diet or nutrition services consultation or progress notes)
- Medication Results (including Medication order sheets, Medication ordering system in the computer)
- Orders (including Physician order sheets, Printed or Electronic order sheets, rt-PA Protocol Sheets)
- Lab Results
- Social services notes

Discharge Data may include:

- Care plans
- Clinical logs
- Clinician encounter sheets
- Consultant reports
- Discharge face sheet
- Discharge form
- Discharge instruction sheet
- Discharge orders
- Discharge summary
- Flow sheets
- Multidisciplinary progress notes
- Nursing discharge notes
- Physician summary
- Referral notes
- Teaching sheets
- Transfer note
- Transfer record
- Physical or occupational therapy consultation or progress notes
- Diet or nutrition services consultation or progress notes

Patient ID

The patient identification number is a unique patient ID number assigned to the patient by the site for that admission. Enter a de-identified number in order to track your patient. Do NOT use date of birth, social security numbers, or medical record numbers. It is recommended that you create a Stroke Registry Log to match up the Patient IDs you create for the Stroke PMT with actual identifiers.

Example: You might use numbers, letters or any combination, e.g. 019A

The Stroke Registry Log is kept confidential and in a secure location at the hospital site. This log is the only means the hospital site has to correlate data in the registry with a specific patient.

Arrival and Admission Information

Where was the patient when stroke was detected or when symptoms were discovered?

Indicate the type of facility or setting from which the patient came from when stroke like symptoms were discovered.

1. Not in a healthcare setting
2. Another acute care facility
3. Chronic health care facility
4. Stroke occurred while patient was an inpatient in your hospital
5. ND or Cannot be determined

Notes for Abstraction

- In the case of a patient transferred to your hospital where they were an inpatient, ED patient, or resident, where was the patient transferred from?
- If the patient was admitted to an ED of another hospital or was an inpatient of another hospital and was transferred to your hospital, choose 2.
- If the patient was a resident of a nursing home, but was out with family for the day and suffered a stroke and the family/EMS brought the patient to your hospital, choose 1.
- If the patient was a resident of a nursing home and the stroke occurred at the NH, and the patient came from the NH to your hospital, choose 3.
- If the patient was an inpatient in your hospital choose 4.
- If the patient was at home, at work, or even a visitor in your hospital and had stroke symptoms, then choose 1. A chronic care facility would include nursing home, long-term care facility, inpatient rehab facility.

S *Pre-hospital Data, Admission Data*

How did the patient get to your hospital for treatment of their stroke?

Indicate the type of transport used to bring the patient to your facility.

- EMS
- Private transportation/taxi/other
- ND or unknown

Choose EMS whenever the patient was brought to your hospital by EMS, whether by ground EMS or Air EMS.
"Other" includes private transportation (e.g. cab, bus, car, walk-in, etc.).

S *Pre-hospital Data, Admission Data*

Date & time of arrival to this Hospital

Documents the earliest time when ED or hospital was aware that there was a patient at their facility that needed to be evaluated.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

Notes for Abstraction

- This may differ from the admission time.
- When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician office records, laboratory reports) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.
- Do not use ambulance records to determine arrival date
- Do not use addressographs/stamps
- If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to the hospital, use the time the patient presents to the ED or arrives on the floor for inpatient care as arrival time.
- For “Direct Admits” to the hospital, use the earliest time the patient arrives at the hospital.

For The Joint Commission purposes, this is known as the arrival date and arrival time.

Admission Data

Demographics

Age

This is the age on the day of admission, calculated from date of birth in medical record. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-92/UB-04 claim information for the birth date is correct. If the abstractor determines through chart review that the UB-92/UB-04 day is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birth date through chart review, she/he should default to the UB-92/UB-04 date of birth.

Admission Data, UB-92/UB-04, Field Location: 14.

Gender

Patient's biological gender as determined by the physician. Options include:

- Male
- Female
- Unknown

Gender will be captured as it is written in medical record - if there is conflict, document with the self-identified gender. For The Joint Commission, this field refers to their data element Sex.

Admission Data, UB-92 Field Location 15.

Hispanic Ethnicity

Ethnicity is not an alternative to race. Both fields should be completed. Other terms for Hispanic ethnicity include: Black-Hispanic, Chicano, H, Hispanic, Latin American, Latino/Latina, Mexican-American, Spanish,

White-Hispanic. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

- Yes
- No
- UTD (Unable to determine)

The data element *Race* is required in addition to this data element.

Example: Patient 005 is Caucasian and reports that she is from Puerto Rico. Check Hispanic/Latino for Ethnicity and select White for Race.

Admission Data

Race

The patient's self-assessed race/ethnicity, or if not available, the physician or institution's assessment. Assumptions should not be made based on physical characteristics. This data allows for analysis of race-related patterns of care. If patient is multi-racial, select each race they designate. Select all that apply from the list provided. Hold down the "Ctrl" key on the keyboard to select multiple options or to deselect an option. Options include:

- White - implies White or origins in Europe, Middle East or North Africa (e.g., Caucasian, Iranian, White)
- Black or African American - would also include Haitian.
- Asian - includes those from the Far East, southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippines, Hmong, Thailand, and Vietnam.
- American Indian/Alaska Native - A person having origins in any of the original peoples of North and South American (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American).
- Native Hawaiian/Pacific Islander - includes persons having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Other
- Unknown

The data element *Hispanic Ethnicity* is required in addition to this data element.
(For The Joint Commission, both Other and Unknown are equivalent to UTD or Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).)

- **Example 1:** Based on physical characteristics, the patient appears to be of Asian descent. When asked, the patient clarifies that she is both African American and Fijian. Check both the Black or African American AND the Pacific Islander boxes.
- **Example 2:** When asked, patient 006 states that she is African American and Filipino. Check boxes for Black or African-American AND Asian.
- **Example 3:** The patient reports he is Afro-Caribbean. Check Black or African American, and note the appropriate ethnicity (Hispanic Yes or No).
- **Example 4:** The patient is aphasic and the race indicated on the Admission sheet is different than on the history and on the ED triage sheet. Check Unknown.

Admission Data

Diagnosis and Evaluation

Clinical hospital diagnosis related to stroke

This is the Stroke or TIA diagnosis defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." Ideally this diagnosis code should be equivalent to the final ICD-9-CM code. However, in some circumstances another ICD-9-CM code may be chosen. When there is a discrepancy, please consult your local Stroke Champion or Stroke Team lead and/or the hospital administrator responsible for assigning ICD-9 codes. Note for Coverdell users, this may be different from the presumptive hospital admission diagnosis.

This field is used to define patient populations in the Stroke Performance Measures.

- Subarachnoid hemorrhage
- Intracerebral hemorrhage
- Ischemic stroke
- Transient ischemic attack
- Stroke not otherwise specified
- No stroke related diagnosis

Admission Data

Symptom Timeline

When was the patient last known to be well (i.e., in their usual state of health or at their baseline), prior to the beginning of the current stroke/TIA? (To within 15 minutes of exact time is acceptable.)

The date and time at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her prior baseline.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

Notes for Abstraction: (TJC)

- The purpose of this data element is to identify the earliest possible time that stroke symptoms began. This is sometimes known as "Onset Time" althgough the use of this term has been confusing to many in the past. If a patient experiences the onset of their symptoms in the company of another individual who can verify that the patient was functioning normally up until the time of start of symptoms, then in this patient the time "last known well" is also the time of symptom discovery. In many cases, however, no one is present at the exact start of symptoms. In this situation, we need to document the time when symptoms were first discovered (time of symptom discovery) as well as the time that the patient was last known to be well or at their baseline (time last known well), and record both of these. The time last known well should be the time closest to the time of discovery for which we have clear evidence that the patient was at their previous baseline. Depending on the type of stroke symptoms, this might be established by a telephone or in person conversation. Family members, EMS personnel, and others, often mistakenly record the time of symptom

discovery as the time the patient was last known well. It is imperative to distinguish these two times to avoid inappropriate use of IV t-PA in patients who are recently discovered to have symptoms but are many hours (>3 hrs) from their time of last being well.

- If a stroke "onset time" is listed in the medical record, without reference to the circumstances preceding its detection, then it should be assumed to be the time "last known well". Enter this time in the specified format. If there is a specific reference to the patient having been discovered with symptoms already present, then this "onset time" should be treated as a "time of symptom discovery" rather than a time of "last known well". If no time of "last known well" can be determined, then "Unknown" should be selected for time "last known well".
- When a time of discovery is documented, but the start of stroke symptoms is not witnessed and no time "last known well" is documented, then "Unknown" should be selected for time "last known well".
- When the start of stroke symptoms is clearly witnessed, then the time "last known well" is identical to the time of symptom discovery.
- If the time of "last known well" is documented as being a specific number of hours prior to arrival (e.g., 2 hours ago) rather than a calendar time, subtract that number from the time of hospital or ED arrival and enter that time as the time "last known well."
- If the time of "last known well" is noted to be a range of time prior to hospital or ED arrival (e.g., "2 - 3 hours ago"), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the time "last known well".
- If there are multiple times of "last known well" documented, either because subsequent more accurate information became available or because of different levels of expertise in sorting out the actual time of "last known well", use the time recorded according to the following hierarchy:
    1. stroke team/neurology
    2. admitting physician
    3. emergency department physician
    4. ED nursing notes
    5. EMS
- The purpose of 'last known well' is to conservatively identify/estimate time of symptom onset. Use "last known well" to identify when the patient was either last seen or last known to be well (well means at the patient's baseline or usual state of health). This may change with various observers. If the last known well time cannot be identified, then indicate that last known well time and/or date is not known.

Examples:

1. Patient 013 arrived in ED via EMS on 12/10/2007 2:43 pm accompanied by her daughter. Her daughter states that patient was found at 2:00 pm "in her chair slumped over, I couldn't understand what she was saying and she was drooling from her mouth - and her face didn't look right." On further questioning by the neurologist, the daughter says her mother ate lunch at 12:30 pm and then went to sit in her chair where she was later found as noted above.

    Time and date of last known well are known as 12/10/2007 12:30, and time and date of discovery are known as 12/10/2007 14:00.

2. Patient 013 arrived in the ED with his son on 11/10/2007 8:09 am. His son states that he last saw his father last night at 8:30 pm. His father lives alone. His father woke up this morning about 6:30 am and noticed that his right arm was weak. It did not get better, so patient called his son at 7:00 am, who came over right away and was concerned that his father was having a stroke, but his father could walk and talk OK. Daughter arrives and states that she had talked to her father on the phone last night around 9:30 pm and that he didn't mention anything about a problem with his arm.

    Time and date of last known well are known as 11/09/2007 21:30, and time and date of discovery are known as 11/10/2007 06:30.

3. Patient 013 was eating dinner with his wife tonight after they finished watching the nightly

news on TV "when his arm began shaking and he couldn't hold onto his fork or his water glass or anything. He has never done this before." Their nightly news show is on from 6:00 to 6:30 pm. She called the ambulance right away. ED arrival date and time is 11/29/2007 7:53 pm.

Time and date of last known well are known as 11/29/2007 18:30, and date of discovery is known as 11/29/2007 with an unknown time. There is no reference to time of discovery in this scenario, so it remains unknown to the abstractor. Above the Date/Time field, select "MM/DD/YYYY" and just enter 11/29/2007.

4. Patient 013 states she has been having numbness come and go in her left arm for the past week, but it always went away. Today the numbness started about 4 hours before she came to the ED and didn't go away so she decided to get it checked. She thinks her arm isn't completely numb, but it feels heavy, and she can't hold a pen tightly. ED arrival time is 5:15 pm on 09/09/2007.

   Time and date of last known well are known as 09/09/2007 13:15, and time and date of discovery are known as 09/09/2007 13:15.

5. Patient 013 was found on the floor beside the commode by the charge nurse at Starlight Nursing Home on her night rounds at 12:45 am on 12/01/2007. He wasn't able to talk or move, but his left leg was shaking. He is normally quite alert and normally walks with his walker. She called 911 right away after conferring with another nurse on duty. According to the evening charge nurse, there were no problems reported with Patient at change of shift. They think that the evening nurse would have seen him between 9 and 10 pm on her rounds. Information was provided by sheet sent from the nursing home. A phone call to the charge nurse does not reveal any further information from the patient's medical chart. ED arrival date and time is 12/01/2007 1:37 am.

   Time and date of last known well are known as 11/30/2007 21:00, and time and date of discovery are known as 12/01/2007 00:45.

6. A 58 y/o woman was last known normal at 7:00 pm and was found at 7:30 pm with right hemiparesis and aphasia. She is transferred to your hospital from another hospital having IV t-PA initiated on 06/10/2007 at 9:30 pm and arrived at your hospital at 10:15 pm.

   Time and date of last known well are known as 06/10/2007 19:00, and time and date of discovery are known as 06/10/2007 19:30.

S *Admission Data, Hospitalization Data*

When was the patient first discovered to have the current stroke symptoms? (To within 15 minutes of exact time of discovery is acceptable.)

Indicate the date and time of discovery of patient's symptoms (i.e., when the patient was found with symptoms). This should be the earliest time that patient was known to have symptoms. This date and time should not vary. If the event was witnessed, then the last known well date and time and the discovery date and time will be identical. Record both, even if identical (checking the box for Time of Discovery same as Last Known Well will automatically set the discovery Date/Time with the same Date/Time as "last known well".)

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

The purpose of this data element is to identify the earliest possible time that stroke symptoms began. This is sometimes known as "Onset Time" althgough the use of this term has been confusing to many in the past. If a patient experiences the onset of their symptoms in the company of another individual who can verify that the patient was functioning normally up until the time of start of symptoms, then in this patient the time "last known well" is also the time of symptom discovery. In many cases, however, no one is present at the exact start of symptoms. In this situation, we need to document the time when symptoms were first discovered (time of symptom discovery) as well as the time that the patient was last known to be well or at their baseline (time last known well), and record both of these. The time last known well should be the time closest to the time of discovery for which we have clear evidence that the patient was at their previous baseline. Depending on the type of stroke symptoms, this might be established by a telephone or in person conversation. Family members, EMS personnel, and others, often mistakenly record the time of symptom discovery as the time the patient was last known well. It is imperative to distinguish these two times to avoid inappropriate use of IV t-PA in patients who are recently discovered to have symptoms but are many hours (>3 hrs) from their time of last being well.

See examples from Last Known Well

 *Admission Data, Hospitalization Data*

Time of Discovery same as Last Known Well

When the onset of symptoms is clearly witnessed, then the time "last known well" is identical to the time of symptom discovery. If this is the case, check this box to automatically fill-in discovery Date/Time with the same Date/Time as "last known well".

Brain Imaging

Was Brain Imaging Performed at your hospital after arrival as part of the initial evaluation for this episode of care or this event?

This question applies to the initial brain image for this event. If patient did not receive any brain imaging at this hospital/facility, then select No/ND. If a patient had outside brain imaging prior to transfer from another hospital, and results for that imaging are recorded in the record, please select NC and record the findings under Initial Brain Imaging Findings.

- Yes
- No/ND
- NC

Admission Data, Hospitalization Data, especially Radiology notes

Date/Time Initial Brain Imaging Completed at your hospital

Enter date and time stamped on the initial CT/MRI of the head performed at your institution. Record only CT/MRI date/time if the first study was performed at your hospital. Please note. If the first brain image is done at an outside hospital, "Outside brain imaging prior to transfer" is selected, and "Date/Time Initial Brain Imaging Completed" should not be filled in. Use the time stamp on the radiology report only if it clearly indicates the time of study completion and NOT time of scheduling, dictation or reporting. If an exact time is not available, see appropriate response categories for

estimates and information not available below.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

Example: If the ED nurses notes document that the head imaging study was done at 10:30 in the morning of November 23, 2004, the data entry would be: 11/23/04 10:30.

Admission Data, Hospitalization Data, especially Radiology notes

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IV Thrombolytic Therapy

Was IV tPA initiated for this patient at this hospital?

Indicate whether IV tPA was initiated at your hospital.

- Yes
- No
- NC

Do not include thrombolytic therapy for indications other than ischemic stroke. That is, do not include intra-cerebral venous infusion for cerebral venous thrombosis, intraventricular infusion for intraventricular hemorrhage, intraparenchymal infusion for percutaneous aspiration of intracerebral hematoma, myocardial infarction, PE, or peripheral clot.

If patient received IV tPA in the ED in your hospital and was then transferred from your ED (without hospital admission) to another acute care hospital, this instance of providing IV tPA by your hospital must be recorded by your hospital even though the patient may not have been formally admitted to your hospital - that is, if this patient was an instance of "drip and ship" IV tPA in this hospital.

Currently, t-PA is the only FDA-approved IV thrombolytic.

Admission Data, Hospitalization Data

Date/Time of IV tPA initiated at this hospital or ED

If IV tPA was initiated at this hospital or ED, record the date and time initiated.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

Notes for Abstraction:

- This data element applies only to patients for whom IV thrombolytic therapy was initiated at this hospital. Do not abstract this data element if IV thrombolytic therapy was initiated at another hospital and patient was subsequently transferred to this hospital.
- IV t-PA is the only FDA-approved IV thrombolytic therapy.

Admission Data, Hospitalization Data

Were one or more of the following reasons for not administering IV thrombolytic therapy at this hospital explicitly documented by a physician, nurse practitioner, or physician assistant's notes in the chart? (Check all that apply)

If no IV tPA was initiated at your hospital, please indicate why not. The following list includes contraindications and warnings from the package insert for IV t-PA, along with a few additional other possible reasons. For further guidance on what kind of patients should or should not be treated with IV t-PA, refer to "Guidelines for the Early Management of Adults With Ischemic Stroke: A Guideline From the American Heart Association/ American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups". See Table 3 for a listing of Characteristics of Patients with Ischemic Stroke Who Could Be Treated With rtPA, taken from the Guidelines.

Contraindications:

- Active internal bleeding (<22 days)
- CT findings (ICH, SAH, or major infarct signs)
- History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor
- Platelets <100,000, PTT> 40 sec after heparin use, or PT > 15 or INR > 1.7, or known bleeding diathesis
- Recent intracranial or spinal surgery, head trauma, or stroke (<3 mo.)
- Recent surgery/trauma (<15 days)
- SBP > 185 or DBP > 110 mmHg despite treatment
- Seizure at onset
- Suspicion of subarachnoid hemorrhage

Warnings:

- Advanced age
- Care-team unable to determine eligibility
- Glucose < 50 or > 400 mg/dl
- Increased risk of bleeding due to Acute pericarditis, SBE, Hemostatic defects, Diabetic hemorrhagic retinopathy, Septic thrombophlebitis or occluded AV cannula, or currently receiving oral anticoagulants, e.g., Warfarin
- IV or IA tPA given at outside hospital
- Left heart thrombus
- Life expectancy < 1 year or severe co-morbid illness or CMO on admission
- Pregnancy
- Pt./Family refused
- Rapid improvement or stroke severity too mild
- Stroke severity – Too severe (e.g., NIHSS >22)

Hospital-related or Other Factors:

- Delay in Patient Arrival
- Failure to diagnose in 3 hour time frame
- Inhospital Time Delay
- No IV access

- Other

Notes for Abstraction:

- Intent of this question is to capture documented contraindications. Check item if documented by physician or nurse in admission or discharge notes. Do not document evidence from outside physician or nurse notes that played a factor in the decision-making process for not giving thrombolytic therapy.
- It is the intent that the abstractor will not make inference as to the reason for non-treatment, but will abstract from documented reasons existing in the medical record.
- "Unable to determine eligibility" means that the diagnosis of stroke was made but that eligibility for thrombolytic therapy could not be established or the clinician could not verify the patient's eligibility for treatment. This might be that the time of onset could not be clearly established at the time of patient assessment in the ED, or that the timing of a recent procedure or surgery could not be definitively established, or time of Last Known Well is unknown.
- Age is a caution - it must be clearly stated in the chart that this was the reason the patient did not receive tPA, and not checked only because the patient is above a certain age.
- Conditions that increase the risk of bleeding or decrease the benefit of treatment to the individual patient must be explicitly listed in the medical record and documented as being the reason that thrombolytics were not used.
- If there is a time delay due to the patient's condition that required other treatment (e.g., intubation, resuscitation), select stroke severity. If there are delays in patient arrival or inhospital processes, select "Time Delay".
- Be very certain that a reason does not logically fit into any of the listed categories before resorting to entering text in "Specify Other reason for non-treatment with IV thrombolytic". Review of the past data reveals that most of the reasons for not giving t-PA will fall into one of the above delineated categories.
- IC/IS = intracranial or intraspinal

The following should help abstractors in classifying reasons:

- If patient is on anticoagulants (Warfarin, Coumadin) and this is documented as the reason for no thrombolytics, and the PT, PTT, or INR is elevated, select that as the reason. If the patient is on anticoagulants and this is documented as the reason, but there is no INR or PTT recorded, then select Increased risk of bleeding.
- If patient declines IV tPA in favor of catheter-based reperfusion or other investigational therapy, then select option "Pt./Family refused"
- If record documents that the reason is "NIHSS low" or something like "NIHSS = 3", then this would appropriately be categorized as stroke severity too mild.
- If the documented reason is something like severe dementia, then select severe co-morbid condition.
- If the diagnosis is unclear, select failure to diagnose.
- If there is a delay in getting the CT done or read, or a delay in patient evaluation, then select other time delay.
- If patients decline IV t-PA and instead select an investigational protocol, select "Pt./Family refused". If there is no evidence that the patient/family was offered IV t-PA, then select "No" for **Was IV tPA initiated for this patient at this hospital?** rather than "NC" since there are no documented reasons for not treating with IV t-PA.

Only use the "Other" field if there is no reason specified that can be accurately captured by the listed choices. Do not select and enter "Other" if you have already selected a specified reason. The "Other" choice will not exclude patients from the denominator of the tPA measures.

Remember to only abstract reasons that are specifically stated as the reason for not giving thrombolytic therapy.

Failure to complete the work up within the 3 hour treatment window or failure to diagnose ischemic stroke is not an excusable reason to not give thrombolytic therapy.

Disclaimer: The reasons provided herein are not intended to supersede physician judgment, but serve as a guideline to abstractors. As always, the physician must exercise due caution in providing treatment, given the risks and benefits to the individual patient and the available information at the time of treatment decision. Reasons have been taken from the package insert for Activase, as well as those used in previous clinical trials.

Admission Data, Hospitalization Data

Was other thrombolytic/reperfusion therapy administered?

IV tPA at an outside hospital

Indicate if IV tPA was initiated at an outside hospital.

- Yes
- No

Admission Data, Hospitalization Data

IA catheter-based reperfusion at this hospital?

Indicate if IA catheter-based reperfusion was initiated at this hospital. IA catheter-based reperfusion therapy includes all uses of IA thrombolytic therapy, as well as mechanical devices such as "Clot retrieval devices". Mechanical devices may be used alone or in conjunction with IA thrombolytic therapy.

- Yes
- No

Admission Data, Hospitalization Data

Date/Time of IA catheter-based reperfusion at this hospital

If IA catheter-based reperfusion was initiated at this hospital or ED, record the date and time initiated.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

The start time for IA catheter-based reperfusion therapy should be either the date and time on the angio showing evidence of treatment, or the start time of the infusion if the angio time is not available.

Admission Data, Hospitalization Data

IA catheter-based reperfusion at outside hospital?

Indicate if IA catheter-based reperfusion was initiated at an outside hospital.

- Yes
- No

Admission Data, Hospitalization Data

In-Hospital Treatment and Complications

Complications of thrombolytic therapy (Check all that apply)

Indicate if there were any complications from the thrombolytic therapy.

- Symptomatic intracranial hemorrhage <36 hours
- Life threatening, serious systemic hemorrhage <36 hours
- No serious complications
- UTD

Notes for Abstraction:

- Definition for symptomatic intracranial hemorrhage: CT hemorrhage shows intracranial bleed AND physician's notes indicate clinical deterioration due to hemorrhage.
- Indicate if hemorrhagic complications of tPA occurred as a result of IV tPA administration within 36 hours from the time of tPA bolus.
- Symptomatic brain hemorrhage is defined by a CT within 36 hours that shows intracranial hemorrhage AND physician's notes indicate clinical deterioration due to hemorrhage.
- Serious systemic hemorrhage is defined by bleeding within 36 hours of IV tPA and > 3 transfused units of blood within 7 days or discharge (whichever is earlier) AND physician note attributing bleeding problem as reason for transfusion
- Indicate if no serious complications occurred.
- Select UTD if worsening stroke symptoms or in-hospital death without confirmed hemorrhage.

Example: Patient 014 received intravenous tPA in the ED on 07/01/04. The following day the patient developed a sudden headache and decreased level of consciousness. A head CT was performed which showed a large intracerebral hemorrhage.

Admission Data, Hospitalization Data, Radiology notes, Discharge Data

If bleeding complications occur in patient transferred after IV t-PA

Indicate if hemorrhagic complications of tPA within 36 hours from the time of tPA bolus, as defined above, occurred in a patient transferred to another healthcare facility after IV tPA administration.

- Symptomatic hemorrhage detected prior to patient transfer
- Symptomatic hemorrhage detected only after patient transfer
- Unable to determine
- N/A

Notes for Abstraction:

- If symptomatic brain or systemic hemorrhage was detected or strongly suspected prior to transfer, select "symptomatic hemorrhage detected prior to patient transfer". Select this option if the patient has hemodynamic instability suggesting systemic hemorrhage, or a deterioration in the neurologic exam suggesting intracerebral hemorrhage while still at the initial treating hospital, even if the testing which confirms the finding doesn't occur until after transfer.
- If symptomatic brain or systemic hemorrhage is not detected or strongly suspected prior to transfer, and occurs only after the patient has left the initial treating facility, select "symptomatic hemorrhage detected only after patient transfer".
- If it is not possible to obtain information from the hospital at which the patient received IV tPA prior to transfer (if you are the receiving hospital), or to which you transferred the patient after starting IV tPA (if you are the initial treating hospital), select "unable to determine". Note that the Federal Privacy Rule (HIPAA) does not restrict the communication of protected health information when performed for quality assurance purposes. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. [These health care operations activities include] conducting quality assessment and improvement activities, population based activities relating to improving health or reducing health care costs, and case management and care coordination; Reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals, accreditation, certification, licensing, or credentialing activities [from The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted on August 21, 1996.]
- Also select "Unable to determine" in case of patient death without confirmed hemorrhage.
- If no tPA given, then this element is not applicable, select N/A.

- **Example 1:** Patient 015 received intravenous tPA in the ED at TMC on 07/01/04 at 11:00 and was transferred to GMC at 13:00. The following day at GMC the patient developed a sudden headache and decreased level of consciousness. A head CT was performed which showed a large intracerebral hemorrhage. Select "symptomatic hemorrhage detected only after patient transfer". If the symptoms began in the ambulance after leaving TMC, you would still select "symptomatic hemorrhage detected only after patient transfer".
- **Example 2** : Patient 015 received intravenous tPA in the ED at TMC on 07/01/04 at 11:00 and developed a sudden headache and decreased level of consciousness prior to transfer to GMC at 13:00. Upon arrival at GMC, a head CT was performed which showed a large intracerebral hemorrhage. Select "symptomatic hemorrhage detected prior to patient transfer".
- **Example 3** : Patient 015 received intravenous tPA in the ED at TMC on 07/01/04 at 11:00 and was transferred to GMC at 13:00. Despite a request by the staff at TMC to the Stroke Center director at GMC, no further information can be obtained about the patient after transfer. Select "unable to determine"

S *Admission Data, Hospitalization Data, Radiology notes, Discharge Data*

Discharge Information

Date of discharge from hospital

The discharge date is the day that the patient is discharged from your institution's acute care unit OR the date of the patient's expiration OR the date of the patient's discharge OR date patient left against medical advice (AMA) OR date of transfer to, a rehabilitating, skilled nursing, or hospice unit in your institution OR transfer to an acute in-patient unit outside of your own institution, even if that hospital is affiliated with your own OR expired.

- Date:MM/DD/YYYY

Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-92/UB-04 claim information for the discharge date is correct. If the abstractor determines through chart review that the UB-92/UB-04 day is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the UB-92/UB-04 date.

Example: Patient 023 is admitted to your in-patient neurology floor from your ED, with a diagnosis of acute ischemic stroke, on January 10, 2004 (01/10/2004). Due to extension of the infarct, need for jejunosotmy and placement, the patient is still on the in-patient unit on January 30, 2004 (01/30/2004). The patient has been on the in-patient unit for 16 days. The patient expires from complications of aspiration pneumonia on February 12, 2004 (02/12/2004). Data entry is 02/12/2004 (MM/DD/YYYY).

Discharge Data, UB-04, (previously UB-92)

Discharge Destination

The patient's discharge destination from acute care is the location where the patient is going for post-acute stay.

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to another short term general hospital for inpatient care
- 03 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification
- 04 Discharged /transferred to an intermediate care facility
- 05 Discharged/transferred to another type of institution for inpatient care
- 06 Discharged/transferred to home under care of organized home health service organization
- 07 Left against medical advice or discontinued care
- 20 Expired (or did not recover - Religious Non Medical Health Care Patient)
- 41 Expired in medical facility, such as hospital, SNF, ICF, or freestanding hospice. Usage note: For use only on Medicare and CHAMPUS (TRICARE) claims for hospice care.
- 43 Discharged/transferred to a federal health care facility Usage note: Discharged and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
- 50 Hospice – home
- 51 Hospice – medical facility (certified) providing hospice level of care
- 61 Discharged/transferred to hospital-based Medicare approved swing bed Usage note: Medicare-used for reporting patients discharged/transferred to a SNF level of care within a hospital's approved swing bed arrangement.
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- 63 Discharge/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under

Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH)

Notes for Abstraction:

- The values for Discharge Destination are taken from the National Uniform Billing Committee Manual (NUBC) manual which is used by the billing/HIM to complete the UB-92/UB-04.
- Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that he UB-92/UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through chart review that the UB-92/UB-04 discharge status is not what is reflected in the medical record, she/he should correct and override the downloaded value.
- It would be appropriate to work with your billing office to develop processes that can be incorporated to improve medical record documentation to support the appropriate discharge status and to ensure consistency between the UB-92/UB-04 discharge status and the medical record.
- If state assigned codes are used, it is the organization's responsibility to ensure that one of the allowable values listed is used.
- While there are additional UB-92/UB-04 values for this data element, they are used for these measures at this time.
- Selection of Discharge codes 02, 07, 20, 41, 50, or 51 will either set the discharge treatments below to NC or disable those fields accordingly.

- **Example1:** Patient 024 was admitted to your institution for new onset stroke symptoms from a local shelter. The patient had partial resolution of symptoms leaving only minor neurologic deficits. The patient was scheduled to be discharged to a shelter on Friday, December 21, 2004 (12/21/2004) with a written care plan for home care services, however patient left the unit prior to discharge and did not return. Check the box for left AMA (07). If the patient had been d/c to shelter with home health, data entry would be to select "06 - Discharged/transferred to home under organized home care".
- **Example 2:** Patient 024 could have been discharged to another local acute care hospital for inpatient care, or to a freestanding rehabilitation facility).

"Did not recover" is specific to the Christian Science religion. They use this term rather than referring to death.

 *Discharge Data, UB-04, (previously UB-92)*